Washington State DEPARTMENT OF SOCIAL & HEALTH SERVICES

Health and Recovery Services Administration

Physical Therapy Program
Billing Instructions

ProviderOne Readiness Edition

[WAC 388-545-0500]

About This Publication

This publication supersedes all previous Department/HRSA *Physical Therapy Program Billing Instructions* published by the Health and Recovery Services Administration, Washington State Department of Social and Health Services. Services and/or equipment related to any of the programs listed below must be billed using their specific billing instructions:

- Hearing Aids and Services
- Home Health Services
- School-Based Healthcare Services
- Neurodevelopmental Centers
- Outpatient Hospital

Note: The Department now reissues the entire billing manual when making updates, rather than just a page or section. The effective date and revision history are now at the front of the manual. This makes it easier to find the effective date and version history of the manual.

Effective Date

The effective date of this publication is: **05/09/2010**.

2010 Revision History

This publication has been revised by:

Document	Subject	Issue Date	Pages Affected

Copyright Disclosure

How Can I Get Department/HRSA Provider Documents?

To download and print Department/HRSA provider numbered memos and billing instructions, go to the Department/HRSA website at http://hrsa.dshs.wa.gov (click the ***Billing Instructions and Numbered Memorandum*** link).

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Important Contacts

Note: This section contains important contact information relevant to Physical Therapy Program. For more contact information, see the Department/HRSA *Resources Available* web page at: http://hrsa.dshs.wa.gov/Download/Resources_Available.html

Topic	Contact Information
Becoming a provider or submitting a change of address or ownership	See the Department/HRSA *Resources Available* web page at: http://hrsa.dshs.wa.gov/Download/Resources_Available.html
Finding out about payments, denials, claims processing, or Department managed care organizations	
Electronic or paper billing	
Finding Department documents (e.g., billing instructions, # memos, fee schedules)	
Private insurance or third-party liability, other than Department managed care	
How do I obtain prior authorization or a limitation extension?	For all requests for prior authorization or limitation extensions, the following documentation is "required:" • A completed, TYPED ProviderOne request form, DSHS 13-835. This request form MUST be the initial page when you submit your request. • A completed Physical, Occupational and Speech Therapy Limitation Extension Request Form, DSHS 13-786, and all the documentation listed on this form and any other medical justification. Fax your request to: 1-866-668-1214. See the Department/HRSA *Resources Available* web page at: http://hrsa.dshs.wa.gov/Download/Resources_Available.html

Definitions & Abbreviations

This section defines terms and abbreviations, including acronyms, used in these billing instructions. Please refer to the Department/HRSA *ProviderOne Billing and Resource Guide* at: http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html for a more complete list of definitions.

Benefit Service Package - A grouping of benefits or services applicable to a client or group of clients.

Department - The state Department of Social and Health Services (the Department).

Maximum Allowable - The maximum dollar amount that a provider may be reimbursed by the Department for specific services, supplies, or equipment.

Medical Identification card(s) – See *Services Card*.

Medically Necessary – See WAC 388-500-0005.

National Provider Identifier (NPI) – A federal system for uniquely identifying all providers of health care services, supplies, and equipment.

Program Visits – Visits based on CPT™ code description. Visits may or may not include time.

ProviderOne – Department of Social and Health Services (the Department) primary provider payment processing system.

ProviderOne Client ID- A system-assigned number that uniquely identifies a single client within the ProviderOne system; the number consists of nine numeric characters followed by WA.
For example: 123456789WA.

Revised Code of Washington (RCW) - Washington State laws.

Services Card – A plastic "swipe" card that the Department issues to each client on a "one- time basis." Providers have the option to acquire and use swipe card technology as one method to access up-to-date client eligibility information.

- The Services Card replaces the paper Medical Assistance ID Card that was mailed to clients on a monthly basis.
- The Services Card will be issued when ProviderOne becomes operational.
- The Services Card displays only the client's name and ProviderOne Client ID number.
- The Services Card does not display the eligibility type, coverage dates, or managed care plans.
- The Services Card does not guarantee eligibility. Providers are responsible to verify client identification and complete an eligibility inquiry.

Usual and Customary Fee - The rate that may be billed to the Department for a certain service or equipment. This rate may not exceed:

- The usual and customary charge that you bill the general public for the same services; or
- If the general public is not served, the rate normally offered to other contractors for the same services.

Physical Therapy

Who Is Eligible to Provide Physical Therapy?
[WAC 388-545-500(1)]

The following providers are eligible to provide physical therapy services:

- A licensed physical therapist or physiatrist; or
- A physical therapist assistant supervised by a licensed physical therapist.

Where Must Physical Therapy Services Be Provided?
[WAC 388-545-500(3)(a-f)]

Physical therapy services that Department-eligible clients receive must be provided as part of an outpatient treatment program:

- In an office, home, or outpatient hospital setting;
- By a home health agency as described in Chapter 388-551 WAC;
- As part of the acute physical medicine and rehabilitation (Acute PM&R) program as described in Acute PM&R subchapter 388-550 WAC;
- By a neurodevelopmental center;
- By a school district or educational service district as part of an individual education or individualized family service plan as described in WAC 388-537-0100; or
- In accordance with the requirements of the Individuals with Disabilities Education Act (IDEA), for early intervention services for disabled children age two and younger.

Referral and Documentation Process

Adults (Age 21 and older) [Refer to WAC 388-545-500(5)]

Providers must document in a client's medical file that physical therapy services provided to clients age twenty-one and older are medically necessary. Such documentation may include justification that physical therapy services:

- Prevent the need for hospitalization or nursing home care;
- Assist a client in becoming employable;
- Assist a client who suffers from severe motor disabilities to obtain a greater degree of self-care or independence; or
- Are a part of a treatment program intended to restore normal function of a body part following injury, surgery, or prolonged immobilization.

Children (Age 20 and younger) (Refer to WAC 388-86-027)

The EPSDT/Healthy Kids screening provider must:

- Determine if there is a medical need for physical therapy; and
- Document the medical need and the referral in the child's physical therapy file.

The physical therapist must:

- Keep referral information on file in the form of a prescription, notes from telephone calls, etc.;
- Contact the referring EPSDT/Healthy Kids screening provider for information concerning the need for physical therapy services; and
- Keep the referring and/or continuing care provider apprised of the assessment, prognosis, and progress of the child(ren) the provider has referred to them for services.

Notifying Clients of Their Right to Make Their Own Health Care Decisions

All Medicare-Medicaid certified hospitals, nursing facilities, home health agencies, personal care service agencies, hospices, and managed health care organizations are federally mandated to give **all adult clients** written information about their rights, under state law, to make their own health care decisions.

Clients have the right to:

- Accept or refuse medical treatment;
- Make decisions concerning their own medical care; and
- Formulate an advance directive, such as a living will or durable power of attorney, for their health care.

Client Eligibility

Who Is Eligible? [WAC 388-545-0500 (2)]

Please see the Department/HRSA *ProviderOne Billing and Resource Guide* at: http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html for instructions on how to verify a client's eligibility.

> **Note:** Refer to the *Scope of Healthcare Services Table* web page at: http://hrsa.dshs.wa.gov/Download/ScopeofHealthcareSvcsTable.html for an up-to-date listing of Benefit Service Packages.

Are Clients Enrolled in a Department Managed Care Plan Eligible? [Refer to WAC 388-538-060 and 095 or WAC 388-538-063 for GAU clients]

YES! When verifying eligibility using ProviderOne, if the client is enrolled in a Department managed care plan, managed care enrollment will be displayed on the Client Benefit Inquiry screen. All services must be requested directly through the client's Primary Care Provider (PCP). Clients can contact their managed care plan by calling the telephone number provided to them.

All medical services covered under a managed care plan must be obtained by the client through designated facilities or providers. The managed care plan is responsible for:

- Payment of covered services; and
- Payment of services referred by a provider participating with the plan to an outside provider.

> **Note:** To prevent billing denials, please check the client's eligibility **prior** to scheduling services and at the **time of the service** and make sure proper authorization or referral is obtained from the plan. See the Department/HRSA *ProviderOne Billing and Resource Guide* at: http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html for instructions on how to verify a client's eligibility.

Coverage

The Department pays only for covered physical therapy services listed in this section when they are:

- Within the scope of an eligible client's medical care program;
- Medically necessary and ordered by a physician, PA, or an ARNP;
- Begun within 30 days of the date ordered;
- For conditions which are the result of injuries and/or medically recognized diseases and defects; and
- Within accepted physical therapy standards. [WAC 388-545-500(4)]

What Is Covered? [Refer to WAC 388-545-500(7-8)]

Note: A program unit is based on the CPT code description. For CPT codes that are timed, each 15 minutes equals one unit. If the description does not include time, the procedure equals one unit regardless of how long the procedure takes.

- The Department does not limit coverage of physical therapy services if the client is 20 years of age or younger.

- The Department covers, without requiring prior authorization, the following ordered physical therapy services per client, per diagnosis, per calendar year, for clients 21 years of age and older:

  - ✓ One physical therapy evaluation. The evaluation is in addition to the 48 program units allowed per year;

  - ✓ 48 physical therapy program units; and

  - ✓ 96 additional outpatient physical therapy program units for the diagnoses listed on the following page.

- The Department covers two DME needs assessments per calendar year. Two physical therapy program units are allowed per assessment.

- The Department covers one wheelchair needs assessment in addition to the DME needs assessment per calendar year. Four physical therapy program units are allowed per assessment.

Additional Coverage (Client 21 years of age and older)

The Department covers a maximum of 96 physical therapy program units in addition to the original 48 units **only** when billed with one of the following diagnoses:

- ***Principal*** diagnosis codes:

Diagnosis Codes	Condition
315.3-315.9, 317-319	For medically necessary conditions for developmentally delayed clients
343 - 343.9	Cerebral palsy
741.9	Meningomyelocele
758.0	Down's syndrome
781.2-781.3	Symptoms involving nervous and musculoskeletal systems, lack of coordination
800-829.1	Surgeries involving extremities-Fractures
851-854.1	Intracranial injuries
880-887.7	Surgeries involving extremities-Open wounds with tendon involvement
941-949.5	Burns
950-957.9, 959-959.9	Traumatic injuries

-OR-

- A completed/approved inpatient Acute Physical Medicine & Rehabilitation (Acute PM&R) when the client no longer needs nursing services but continues to require specialized outpatient therapy for:

Diagnosis Codes	Condition
854	Traumatic Brain Injury (TBI)
900.82, 344.0, 344.1	Spinal Cord Injury, (Paraplegia & Quadriplegia)
436	Recent or recurrent stroke
340	Restoration of the levels of function due to secondary illness or loss for, Multiple Sclerosis (MS)
335.20	Amyotrophic Lateral Sclerosis (ALS)
343 – 343.9	Cerebral Palsy (CP)
357.0	Acute infective polyneuritis (Guillain-Barre syndrome)
941.4, 941.5, 942.4, 942.5, 943.4, 943.5, 944.4, 944.5, 945.4,	Extensive Severe Burns
707.0 and 344.0	Skin Flaps for Sacral Decubitus for Quads only
890 – 897.7, 887.6 – 887.7	Open wound of lower limb, Bilateral Limb Loss

Physical Therapy Program Limitations

Duplicate services for Occupational, Physical, and Speech therapy are not allowed for the same client when both providers are performing the same or similar procedure(s).
[WAC 388-545-500 (11)]

Note: A program unit is based on the CPT code description. For CPT codes that are timed, each 15 minutes equals one unit. If the description does not include time, the procedure equals one unit regardless of how long the procedure takes.

If time is included in the CPT code description, the beginning and end times of each therapy modality must be documented in the client's medical record.

The following CPT codes are considered part of the physical therapy program 48-unit limitation:

97012	97034	97140
97014	97035	97150
97016	97036	97530
97018	97039	97535
97022	97110	97537
97024	97112	97750
97026	97113	97755
97028	97116	97761
97032	97124	
97033	97139	

The following CPT codes are not included in the physical therapy program 48-unit limitation [Refer to WAC 388-545-500 (8)]:

CPT Codes	Coverage
95831 95832 95833 95834	One muscle testing procedure is allowed per day. Muscle testing procedures cannot be billed in combination with each other. These procedures can be billed alone or with other physical therapy CPT codes.
97001	Allowed once per calendar year, per client. Use CPT code 97001 to report the initial evaluation before the plan of care is established by the physical therapist or the physician. This is to evaluate the client's condition and establishing the plan of care.
97002	Allowed once per calendar year, per client. CPT code 97002 is for reporting the re-evaluation of a client who has been under a plan of care established by a physician or physical therapist. This evaluation is for reevaluating the client's condition and revising the plan of care under which the client is being treated.
97542	Limited to one wheelchair assessment per calendar year, per client. Assessment is limited to 4 15-minute units per assessment. Indicate on claim this is a "wheelchair needs" assessment.
97760	Two units are allowed per day. This procedure can be billed alone or with other physical therapy CPT codes.
97762	Providers must bill this code for DME assessments. Payment is limited to two assessments per calendar year, with two 15-minute increments (units) per session.
97762	Providers must bill this code for DME assessments. Payment is limited to two assessments per calendar year, with two 15-minute increments (units) per session. **Use TS Modifier for follow-up service.**
97597 97598 97602	The Department reimburses Physical Therapists for active wound care management involving selective and non-selective debridement techniques to promote healing using CPT codes. The following conditions apply: • The Department allows one unit of CPT code 97597 **or** 97598 **or** 97602 per client, per day. Providers may not bill CPT codes 97597, 97598, or 97602 in conjunction with one another. • Providers must not bill procedure codes 97597, 97598, and 97602 in addition to CPT codes 11040-11044.

How Do I Request Approval to Exceed the Limits?

For clients 21 years of age and older who need physical therapy beyond that which is allowed by diagnosis, the provider must request Department approval to exceed the limits.

Limitation extensions (LEs) and expedited prior authorization (EPA) numbers do not override the client's eligibility or program limitations. Not all eligibility groups receive all services.

> **Note:** Please see the Department/HRSA *ProviderOne Billing and Resource Guide* at: http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html for more information on requesting authorization.

Limitation Extensions

Limitation Extensions are cases where a provider can verify that it is medically necessary to provide more units of service than allowed in Department/HRSA billing instructions and Washington Administrative Code (WAC). Providers must use the EPA process to create their own EPA numbers. These EPA numbers are subject to post payment review.

In cases where the EPA cannot be met and the provider feels that additional services are medically necessary, the provider must request Department approval for limitation extension. The request must state the following in writing:

1. The name and ProviderOne Client ID of the client;
2. The therapist's name, NPI, and fax number;
3. The prescription for therapy from the provider. A letter describing the client's condition and the need for therapy is helpful;
4. The number of units and procedure codes used during calendar year;
5. The number of additional units and procedure codes needed;
6. The most recent therapy progress notes;
7. Copy of the physical therapy evaluation;
8. If therapy is related to an injury or illness, the date(s) of injury or onset of illness;
9. If surgery has been done, date(s) of surgery;
10. The primary diagnosis or ICD-9-CM diagnosis code; and
11. The reason why the client needs more therapy and why he or she is not independent in a home exercise program.

Send your request to the Department (see the Important Contacts section).

Expedited Prior Authorization (EPA)

The EPA process is designed to eliminate the need for written authorization. The intent is to establish authorization criteria and identify these criteria with specific codes, enabling providers to create an "EPA" number when appropriate.

To bill the Department for diagnoses, procedures and services that meet the EPA criteria on the following pages, the provider must **create a 9-digit EPA number**. The first six digits of the EPA number must be **870000**. The last 3 digits must be the code number of the diagnostic condition, procedure, or service that meets the EPA criteria. Enter the EPA number on the billing form in the authorization number field, or in the *Authorization* or *Comments* field when billing electronically. With HIPAA implementation, multiple authorization (prior/expedited) numbers can be billed on a claim. If you are billing multiple EPA numbers, you must list the 9-digit EPA numbers in **field 19** of the claim form **exactly** as follows (*not all required fields are represented in the example*):

19. Line 1: 870000725/ Line 2: 870000726

If you are only billing one EPA or PA number on a paper 1500 Claim Form, please continue to list the 9-digit EPA number in field 23 of the claim form.

Example: The 9-digit authorization number for additional physical therapy units for a client who has used 48 PT units this calendar year and subsequently has had knee surgery, would be **870000640** (**870000** = first six digits of all expedited prior authorization numbers, **640** = last three digits of an EPA number indicating the service and which criteria the case meets).

Expedited Prior Authorization Guidelines

A. Diagnoses

Only diagnostic information obtained from the hospital or outpatient chart may be used to meet conditions for EPA. Claims submitted without the appropriate diagnosis, procedure code or service as indicated by the last three digits of the EPA number will be denied.

B. Documentation

The billing provider must have documentation of how expedited criteria was met, and have this information in the client's file available to the Department on request.

Washington State
Expedited Prior Authorization (EPA) Criteria Coding List
For Physical Therapy (PT) LEs

Procedure Code	EPA Code	Description	Criteria
Physical Therapy			
97012-97150, 97530-97537, 97750, 97755, 97761	640	An additional 48 Physical Therapy program units	When the client has already used the allowed program units for the current year and has **one** of the following surgeries or injuries: 1. Lower extremity joint surgery; 2. CVA not requiring acute inpatient Rehabilitation; or 3. Spine surgery
	641	An additional 96 Physical Therapy program units	When the client has already used the allowed program units for the current year and has recently completed an acute inpatient rehabilitation stay.

Are School-Based Healthcare Services Covered?

The Department covers occupational therapy services provided in a school setting for school-contracted services that are noted in the client's Individual Education Program (IEP) or Individualized Family Service Plan (IFSP). Refer to the current Department/HRSA *School-Based Healthcare Services Billing Instructions*. See the *Important Contacts* Section.

What Is Not Covered? **[WAC 388-545-500(12) and (13)]**

- The Department does not cover physical therapy services that are included as part of the reimbursement for other treatment programs. This includes, but is not limited to, hospital inpatient and nursing facility services.

- The Department does not cover physical therapy services performed by a physical therapist in an outpatient hospital setting when the physical therapist is not employed by the hospital. Reimbursement for services must be arranged through the hospital.

Coverage Table and Fee Schedule

Note: Due to its licensing agreement with the American Medical Association, the Department publishes only the official, brief CPT code descriptions. To view the full descriptions, please refer to your current CPT book.

Note: A program unit is based on the CPT code description. For CPT codes that are times, each 15 minutes equals one unit. For CPT codes that are time periods, each 15 minutes equals one unit. If the description does not include a time period, the procedure equals one unit regardless of how long the procedure takes.

Procedure Code	Modifier	Brief Description	EPA/PA	Policy/ Comments
Muscle Testing				
95831		Limb muscle testing, manual		One muscle testing procedure is allowed per day. Muscle testing procedures cannot be billed in combination with each other. These procedures can be billed alone or with other physical therapy CP codes.
95832		Hand muscle testing, manual		
95833		Body muscle testing, manual		
95834		Body muscle testing, manual		
95851		Range of motion measurements		
95852		Range of motion measurements		
Tests and Measurements				
96125		Cognitive test by hc pro		Limit of one per calendar year, per client
97001		PT evaluation		Allowed once per calendar year, per client. Use this code for the initial evaluation.
97002		PT re-evaluation		Allowed once per calendar year, per client. Use this code for re-evaluation.
97005		Athletic train eval		Not covered
97006		Athletic train re-eval		Not covered

Procedure Code	Modifier	Brief Description	EPA/PA	Policy/ Comments
Modalities				
97010*		Hot or cold packs therapy		Bundled service
97012*		Mechanical traction therapy		
97014*		Electrical stimulation therapy		
97016*		Vasopneumatic device therapy		
97018*		Paraffin bath therapy		
97022*		Whirlpool therapy		
97024*		Diathermy treatment		
97026*		Infrared therapy		
97028*		Ultraviolet therapy		
97032*		Electrical stimulation		
97033*		Electrical current therapy		
97034*		Contrast bath therapy		
97035*		Ultrasound therapy		
97036*		Hydrotherapy		
97039*		Physical therapy treatment		
Therapeutic Procedures				
Note: Therapy provider is required to be in constant attendance.				
97110*		Therapeutic exercises		
97112*		Neuromuscular re-education		
97113*		Aquatic therapy/exercises		
97116*		Gait training therapy		
97124*		Massage therapy		
97139*		Physical medicine procedure		
97140*		Manual therapy		
97150*		Group therapeutic procedures		
97530*		Therapeutic activities		
97533		Sensory integration		Not covered
97535*		Self care mngment training		
97537*		Community/work reintegration		

An asterisk (*) means the code is included in the 48 visit limitation (applies to clients 21 and over).

Procedure Code	Modifier	Brief Description	EPA/PA	Policy/ Comments
Therapeutic Procedures Continued				
Note: Therapy provider is required to be in constant attendance.				
97542		Wheelchair mngment training		Limited to one wheelchair assessment per calendar year, per client. Assessment is limited to 4 15-minute units per assessment. Indicate on claim this is a "wheelchair needs" assessment.
97545		Work hardening		Not covered
97546		Work hardening add-on		Not covered
97597	59 for multiple wounds	Active wound care/20 cam or <		The Department reimburses Physical Therapists for active wound care management involving selective and non-selective debridement techniques to promote healing using CPT codes. The following conditions apply: The Department allows one unit of CPT code 97597 or 97598 or 97602 per client, per day. Providers may not bill CPT codes 97597, 97598, or 97602 in conjunction with one another. Providers must not bill procedure codes 97597, 97598, and 97602 in addition to CPT codes 11040-11044.
97598	59 for multiple wounds	Active wound care > 20 cm		
97602	59 for multiple wounds	Wound(s) care non-selective		
97605		Neg press wound tx, <50 cm		Bundled service
97606		Neg press wound tx, >50 cm		Bundled service

Procedure Code	Modifier	Brief Description	EPA/PA	Policy/ Comments
An asterisk (*) means the code is included in the 48 visit limitation (applies to clients 21 and over).				
Therapeutic Procedures Continued				
Note: Therapy provider is required to be in constant attendance.				
97750*		Physical performance test		Do not use to bill for an eval (97001) or re-eval (97002)
97755*		Assistive technology assess	PA	
97760		Orthotic mgmt and training		Limited to 2 15-minute units per day. Can be billed alone or with other PT CPT codes.
97761*		Prosthetic training		
97762		C/o for orthotic/prosth use		The Department covers two DME needs assessments per calendar year, per client. Limited to 2 15-minute units per day. Can be billed alone or with other PT CPT codes.
97799		Physical medicine procedure		Documentation needs to be attached to claim.

Fee Schedule

You may view the Department/HRSA **Physical Therapy Program Fee Schedule** on-line at:

http://hrsa.dshs.wa.gov/RBRVS/Index.html#p

Billing and Claim Forms

What Are the General Billing Requirements?

Providers must follow the Department/HRSA *ProviderOne Billing and Resource Guide* at: http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html. These billing requirements include, but are not limited to:

- Time limits for submitting and resubmitting claims and adjustments;
- What fee to bill the Department for eligible clients;
- When providers may bill a client;
- How to bill for services provided to primary care case management (PCCM) clients;
- Billing for clients eligible for both Medicare and Medicaid;
- Third-party liability; and
- Record keeping requirements.

Completing the CMS-1500 Claim Form

Note: Refer to the Department/HRSA *ProviderOne Billing and Resource Guide* at: http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html for general instructions on completing the CMS-1500 Claim Form.

Instructions Specific to Physical Therapy Providers

The following CMS-1500 Claim Form instructions relate to the Physical Therapy Program:

<table>
<tr><th>Field No.</th><th>Name</th><th>Entry</th></tr>
<tr><td>24B.</td><td>Place of Service</td><td>These are the only appropriate codes for this program:

Code Number — To Be Used For
11 — Office
12 — Home
62 — Comprehensive Outpatient Rehabilitation Facility
99 — Other</td></tr>
</table>